Air North Care First

COVID-19 Medical Form

Passenger Information

PASSENGER NAME (PLEASE PRINT)	FLIGHT ROUTE
EMAIL ADDRESS	DATE(S) OF TRAVEL (MM/DD/YY)
PHONE NUMBER	BOOKING ITINERARY NUMBER
HOME ADDRESS	ADDRESS AT DESTINATION

Physician Information

PHYSICIAN NAME	OFFICE ADDRESS
LICENSE NUMBER	
JURISDICTION OF REGISTRATION	EMAIL ADDRESS
	PHONE NUMBER

Section I

To be completed if a passenger is exhibiting symptoms of COVID-19 that are not related to possible infection or a positive test result.
The above-named patient has a medical condition(s) that presents with:

- ☐ A fever and/or;
- ☐ A cough and/or;
- ☐ Breathing difficulties
- ☐ A temperature of 38°C or above

I hereby certify that these symptoms are not related to COVID-19:

PHYSICIAN'S INITIALS

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Section II

To be completed if a passenger is to be exempted from wearing the mandatory face covering.

The above-named patient has a medical condition that restricts the wearing of a face mask or face covering as follows:

Signatures and Authorization

Both the physician and the passenger must sign below.

I hereby certify the information herein to be true and correct, and that the named patient is fit for travel on (MM/DD/YY)

or between (MM/DD/YY) and (MM/DD/YY) up until (MM/DD/YY) .

Physician

PHYSICIAN NAME (PRINTED)
PHYSICIAN SIGNATURE
DATE

Passenger

PASSENGER NAME (PRINTED)
PASSENGER SIGNATURE
DATE

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